DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

Form Approved
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION

TRANSMITTAL NUMBER: MS 90-6
STATE: Missouri
PROGRAM IDENTIFICATION: Title XIX

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

PROPOSED EFFECTIVE DATE: March 1, 1990

TYPE OF PLAN MATERIAL (Check One)

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE NEXT 4 BLOCKS IF THIS IS AN AMENDMENT (Separate transmittal for each amendment)

FEDERAL REGULATION CITATION: 42 CFR 447 Subpart C

NUMBER OF THE PLAN SECTION OR ATTACHMENT	NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT
Attachment 4.19-D	Attachment 4.19-D
age: 42-71 And Assurances	Page: 42-71

SUBJECT OF AMENDMENT

Updating provisions of Long-Term Reimbursement Plans for ICF/MR to reflect changes implemented during the Jan-March 1990 quarter. This Amendment establishes a Prospective Reimbursement Plan for Non-State Operated facilities for ICF-MR Services.

GOVERNOR'S REVIEW (Check One)

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT JP
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

SIGNATURE OF STATE AGENCY OFFICIAL

TYPED NAME: Gary J. Stangler

TITLE: Director, Department of Social Services

DATE: March 26, 1990

RETURN TO:
Division of Medical Services
P.O. Box 6500
Jefferson City, MO 65102-6500

FOR REGIONAL OFFICE USE ONLY

DATE RECEIVED: 03/26/90
DATE APPROVED: JUN 06 2001

PLAN APPROVED – ONE COPY ATTACHED

EFFECTIVE DATE OF APPROVED MATERIAL: 3/1/90

SIGNATURE OF REGIONAL OFFICIAL

TYPED NAME: Thomas W. Lenz

TITLE: ARA for Medicaid & State Operations

REMARKS:

cc: Martin/Vadner/Waite/CO

Form HCFA-179 (3/80) (Formerly PCO-11) Submit 6 Copies.

APPENDIX

Findings and Assurances

In conformity with the Title 42 CFR Section 447.253(a) and (b), the Department of Social Services/Division of Medical Services (DSS/DMS) makes the following findings and assurances:

- ICF-MR rates of payment have been found to be reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

- The estimated weighted average proposed payment rate is reasonably expected to pay no more in the aggregate for ICF-MR, Long-Term Care services to state-operated facilities than the amount that the agency reasonably estimates would be paid for the services under the Medicare principles of reimbursement.

- DSS/DMS provides long-term care facilities with an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review of payment rates with respect to such issues as DSS/DMS determines appropriate.

- DSS/DMS requires the filing of uniform cost reports by each participating provider.

- DSS/DMS provides for periodic audits of the financial and statistical records of participating providers.

- DSS/DMS published prior notice of said change in the newspaper in accordance with 42 CFR 447.205(d)(2)(ii).

- DSS/DMS pays for long-term care services using rates determined in accordance with methods and standards specified in the approved State Plan.

- The payment methodology used by the State for payments to ICF-MR facilities for medical assistance beginning January 1, 1990 can reasonably be expected not to increase payments solely as a result of a change of ownership in excess of the increase which would result from application of 42 U.S.C. 1861 (v)(1)(0) of the Social Security Act for all changes of ownership which occur on or after July 18, 1984, except for those changes made pursuant to an enforceable agreement executed prior to that date.

ARP

JUN 06 2001

- Section (2)(B)3 ICF-MR of the State's Prospective Reimbursement Plan for Non-State Operated Facilities for ICF-MR services provides that a change in ownership/management of a facility is not subject to review for rate reconsideration. Under the State's current methodology, ICF/MR payment rates do not increase as a result of a change in ownership.

- The state assures that valuation of capital assets for purposes of determining payment rates for long-term care facilities will not be increased, solely as a result of a change of ownership, by more than as may be allowed under section 1902 (a)(13)(C) of the Act.

Related Information

In conformity with Title 42 CFR Section 447.255, DSS/DMS is submitting with the findings and assurances the following related information:

- DSS/DMS has determined a projected weighted average per diem rate for ICF-MR, long-term care providers after the effective date of the proposed plan amendment.

Provider Type	Before 3/1/90	After 3/1/90	Increase/ Decrease
Non-State-Operated ICF/MR	$114.18	$114.18	-0-

- DSS/DMS estimates there is no significant impact resulting from the change, either in short-term or long-term effects, as affecting -

  (1) The availability of services on a statewide and geographic area basis;
  (2) The type of care furnished; and
  (3) The extent of provider participation

ate Plan TN# 90-06 Effective Date 3/1/90
persedes TN# Approval Date JUN 06 2001

13 CSR 70-10.030 Prospective Reimbursement Plan for Non-State Operated ICF/MR Services.

(1) PURPOSE: This rule establishes a payment plan for Non-State Operated ICF/MR services. The plan describes principles to be followed by Title XIX ICF/MR providers in making financial reports and presents the necessary procedures for setting rates, making adjustments and auditing the cost reports.

(2) General Principles.

(A) The Missouri Medical Assistance program shall reimburse qualified providers of ICF/MR services based solely on the individual Medicaid recipient's days of care (within benefit limitations) multiplied by the facility's Title XIX per-diem rate less any payments made by recipients.

(B) Effective November 1, 1986 the Title XIX per-diem rate for all ICF/MR facilities participating on or after October 31, 1986 shall be the lower of --

1. The average private pay charge;

2. The Medicare per-diem rate, if applicable; or

3. The rate paid to a facility on October 31, 1986, as adjusted by updating its base year to its 1985 fiscal year. Facilities which do not have a full twelve (12)-month 1985 fiscal year shall not have their base years updated to their 1985 fiscal years. Changes in ownership, management, control, operation, leasehold interests by whatever form for any facility previously certified for participation in the Medicaid program at any time that results in increased capital costs for the successor owner, management or leaseholder shall not be recognized for purposes of reimbursement.

4. However, any provider who does not have a rate on October 31, 1986, and whose facility meets the definition in subsection (3)(K) of this plan, will be exempt from paragraph (2)(B)3. and the rate shall be determined in accordance with applicable provisions of this regulation.

(C) In no case may the per-diem reimbursement rate under the provisions of this plan exceed the level of care ceiling.

(D) This plan has an effective date of November 1, 1986, at which time prospective per-diem rates shall be calculated for the remainder of the state's fiscal year 1987 and future fiscal years. Per-diem rates established by updating facilities' base years to fiscal year 1985 may be subject to retroactive and prospective adjustment based on audit of the facilities' new base year period.

(E) The Title XIX per-diem rates as determined by this plan shall apply only to services furnished on or after November 1, 1986.

(3) Definitions

(A) Effective Date

1. The plan effective date shall be November 1, 1986.

2. The effective date for rate adjustments granted in accordance with section (6) of this plan shall be for dates of service beginning the first day of the month following the director's, or his/her designee's, final determination on the rate.

(B) Medicare rate is the allowable cost of care permitted by Medicare standards and principles of reimbursement.

(C) Cost Report. The cost report shall detail the cost of rendering covered services for the fiscal reporting period. Providers must file the cost report on forms provided by and in accordance with the procedures of the department.

(D) Department. The department, unless otherwise specified, refers to the Missouri Department of Social Services.

(E) Director. The director, unless otherwise specified, refers to the director, Missouri Department of Social Services.

(F) Providers. A provider under the Prospective Reimbursement Plan is a Non-State Operated ICF/MR facility with a valid participation agreement, in effect on or after October 31, 1986, with the Missouri Department of Social Services for the purpose of providing long-term care services to Title XIX eligible recipients. Facilities certified to provide intermediate care services to the mentally retarded under the Title XIX program may be offered a Medicaid participation agreement on or after January 1, 1990 only if 1) the facility has no more than fifteen (15) beds for mentally retarded residents and 2) there is no other licensed residential living facility for mentally retarded individuals within a radius of one-half (1/2) mile of the facility seeking participation in the Medicaid program.

(G) Average Private Pay Charge. The average private pay charge is the usual and customary charge for non-Medicaid patients determined by dividing total non-Medicaid days of care into total revenue collected for the same service that is included in the Medicaid per-diem rate, excluding negotiated payment methodologies with the Veteran's Administration and the Missouri Department of Mental Health.

(H) Level of Care Ceiling. One hundred thirty-five percent (135%) of the weighted mean rate paid for the non-state operated ICF/MR level of care group in effect on March 1, 1990, provided that on July 1, 1990, and annually thereafter, the per-diem reimbursement rate as adjusted by the negotiated trend factor may be used as the basis for the level of care ceiling computed for the subsequent year.

(I) Reasonable and Adequate Reimbursement. Reimbursement levels which meet the needs of an efficiently and economically operated facility and which in no case exceed normal market costs.

(J) Allowable Cost Areas. Those cost areas which are allowable for allocation to the Medicaid program based upon the principles established in this plan. The allowability of cost areas not specifically addressed in

this plan will be based upon criteria of the Medicare Provider Reimbursement Manual (HIM-15) and section (7) of this rule.

(K) New Construction. Newly built facilities or parts, for which an approved Certificate of Need or applicable waivers were obtained and which were newly completed and operational on or after November 1, 1986.

(L) Committee. The advisory committee defined in subsection (6)(A) of this rule.

(M) New Owners. Original owners of new construction.

(N) ICF/MR Facility: Non-State Operated facilities certified to provide intermediate care for the mentally retarded under the Title XIX program.

(O) Related Parties. Parties are related when --

1. An individual or group, regardless of the business structure of either, where through their activities, one (1) individual's or group's transactions are for the benefit of the other and the benefits exceed those which are usual and customary in the dealings;

2. One (1) or more persons has an ownership or controlling interest in a party; and the person(s), or one (1) or more relatives of the person(s), has an ownership or controlling interest in the other party. For the purposes of this paragraph, ownership or controlling interest does not include a bank, savings bank, trust company, building and loan association, savings and loan association, credit union, industrial loan and thrift company, investment banking firm or insurance company unless the entity directly or through a subsidiary, operates a facility; or

3. As used in the section, the following terms mean --

A. Indirect ownership/interest means an ownership interest in an entity that has an ownership interest in another entity. This term includes an ownership interest in any entity that has an indirect ownership interest in an entity;

B. Ownership interest means the possession of equity in the capital, in the stock or in the profits of an entity;

C. Ownership or controlling interest is when a person or corporation(s) --

(I) Has an ownership interest totalling five percent (5%) or more in an entity;

(II) Has an indirect ownership interest equal to five percent (5%) or more in an entity. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity;

(III) Has a combination of direct and indirect ownership interest equal to five percent (5%) or more in an entity;

(IV) Owns an interest of five percent (5%) or more in any mortgage, deed of trust, note or other obligation secured by an entity if that interest equals at least five percent (5%) of the value of the property or assets of the entity. The percentage of ownership resulting from the obligations is determined by multiplying the percentage of interest owned in the obligation by the percentage of the entity's assets used to secure the obligation;

(V) Is an officer or director of an entity; or

(VI) Is a partner in an entity that is organized as a partnership;

D. Relative means persons related by blood or marriage to the fourth degree of consanguinity; and

E. Entity means any person, corporation, partnership or association.

(P) Urban. The urban counties are standard metropolitan statistical areas including Andrew, Boone, Buchanan, Cass, Christian, Clay, Franklin, Greene, Jackson, Jasper, Jefferson, Newton, Platte, Ray, St. Charles, St. Louis and St. Louis City.

(Q) Rural. Those counties which are not defined as urban.

(4) Prospective Reimbursement Rate Computation

(A) Except in accordance with other provisions of this rule, the provisions of this section shall apply to all providers of ICF/MR services certified to participate in Missouri's Medicaid program.

1. ICF/MR Facilities

A. Except in accordance with other provisions of this rule, the Missouri Medical Assistance program shall reimburse providers of these long-term care services based on the individual Medicaid-recipient days of care multiplied by the Title XIX prospective per-diem rate less any payments collected from recipients. The Title XIX prospective per-diem reimbursement rate for the remainder of state fiscal year 1987 shall be the facility's per-diem reimbursement payment rate in effect on October 31, 1986, as adjusted by updating the facility's allowable base year to its 1985 fiscal year. Each facility's per-diem costs as reported on its fiscal year 1985 Title XIX cost report will be determined in accordance with the principles set forth in this regulation. If a facility has not filed a 1985 fiscal year cost report, the most current cost report on file with the department will be used to set its per-diem rate. Facilities with less than a full twelve (12)-month 1985 fiscal year will not have their base year rates updated.

B. For state fiscal year 1988 and dates of service beginning July 1, 1987 the negotiated trend factor shall be equal to two percent (2%) to be applied in the following manner: Two percent (2%) of the average per-diem rate paid to both State Operated and Non-State Operated ICF/MR facilities on June 1, 1987 shall be added to each facility's rate.

C. For state fiscal year 1989 and dates of service beginning January 1, 1989, the negotiated trend factor shall be equal to one percent (1%) to be applied in the following manner: One percent (1%) of the average per-diem rate paid to both State Operated and Non-State Operated ICF/MR facilities on June 1, 1988 shall be added to each facility's rate.

2. Adjustments to Rates. The prospectively determined reimbursement rate may be adjusted only under the following conditions:

A. When information contained in a facility's cost report is found to be fraudulent, mispresented or inaccurate, the facility's reimbursement rate may be both retroactively and prospectively reduced if the fraudulent, misrepresented or inaccurate information as originally reported resulted in establishment of a higher reimbursement rate than the facility would have received in the absence of such information. No decision by the Medicaid agency to impose a rate adjustment in the case of fraudulent, misrepresented or inaccurate information shall in any way affect the Medicaid agency's ability to impose any sanctions authorized by statute or regulation. The fact that fraudulent, misrepresented or inaccurate information reported did not result in establishment of a higher reimbursement rate than the facility would have received in the absence of such information also does not affect the Medicaid agency's ability to impose any sanctions authorized by statute or regulation;

B. In accordance with subsection (6)(B) of this rule, a newly constructed facility's initial reimbursement rate may be reduced if the facility's actual allowable per diem cost for its first twelve (12) months of operation is less than its initial rate;

C. When a facility's Medicaid reimbursement rate is higher than either its private pay rate or its Medicare rate, the Medicaid rate will be reduced in accordance with subsection (2)(B) of this rule;

D. When the provider can show that it incurred higher cost due to circumstances beyond its control and the circumstance is not experienced by the nursing home or ICF/MR industry in general, the request must have a substantial cost effect. These circumstances include but are not limited to:

(I) Acts of nature such as fire, earthquakes and flood that are not covered by insurance,

(II) Vandalism and/or civil disorder; or

(III) Replacement of capital depreciable items not built into existing rate that are the result of circumstances not related to normal wear and tear or upgrading of existing system;

E. When an adjustment to a facility's rate is made in accordance with the provisions of section (6) of this rule; or

F. When an adjustment is based on an Administrative Hearing Commission or court decision.

(B) In the case of newly constructed non-state operated ICF/MR facilities entering the Missouri Medicaid program after October 31, 1986 and for which no rate has previously been set, the director or his/her designee may set an initial rate for the facility as in his/her discretion s/he deems appropriate. The initial rate shall be subject to review by the advisory committee under the provisions of section (6) of this regulation.

(5) Covered Services and Supplies

(A) ICF/MR services and supplies covered by the per-diem reimbursement rate under this plan, and which must be provided, as required by Federal or state law or regulation and include, among other services, the regular room, dietary and nursing services, or any other services that are required for standards of participation or certification, also included are minor medical and surgical supplies and the use of equipment and facilities. These items include, but are not limited to, the following:

1. All general nursing services including, but not limited to, administration of oxygen and related medications, hand-feeding, incontinency care, tray service and enemas;

2. Items which are furnished routinely and relatively uniformly to all recipients; for example, gowns, water pitchers, soap, basins and bed pans;

3. Items such as alcohol, applicators, cotton balls, bandaids and tongue depressors;

4. All nonlegend antacids, nonlegend laxatives, nonlegend stool softeners and nonlegend vitamins. Any and all nonlegend drugs in one of these four (4) categories must be provided to residents as needed and no additional charge may be made to any party for any of these drugs. Facilities may not elect which nonlegend drugs in any of the four (4) categories to supply; all must be provided as needed within the existing per-diem rate;

5. Items which are utilized by individual recipients but which are reusable and expected to be available such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment and other durable, non-depreciable medical equipment;

6. Additional items as specified in the appendix to this plan when required by the patient;

7. Special dietary supplements used for tube feeding or oral feeding such as elemental high nitrogen diet including dietary supplements written as a prescription item by a physician;

8. All laundry services except personal laundry which is a non-covered service;

9. All general personal care services which are furnished routinely and relatively uniformly to all recipients for their personal cleanliness and appearance shall be covered services; for example, necessary clipping and cleaning of fingernails and toenails, basic hair care, shampoos and shaves to

the extent necessary for reasonable personal hygiene. The provider shall not bill the patient or his/her responsible party for this type of personal service;

10. All consultative services as required by state or federal law or regulation or for proper operation by the provider. Contracts for the purchase of these services must accompany the provider cost report. Failure to do so will result in the penalties specified in section (9) of this rule;

11. Semi-private room and board and private room and board when necessary to isolate a recipient due to a medical or social condition, such as contagious infection, irrational loud speech, etc. Unless a private room is necessary due to such a medical or social condition, a private room is a non-covered service and a Medicaid recipient or responsible party may therefore pay the difference between a facility's semiprivate charge and its charge for a private room. Medicaid recipients may not be placed in private rooms and charged any additional amount above the facility's Medicaid per-diem unless the recipient or responsible party in writing specifically requests a private room prior to placement in a private room and acknowledges that an additional amount not payable by Medicaid will be charged for a private room;

12. Twelve (12) days per any period of six (6) consecutive months during which a recipient is on a temporary leave of absence from the facility. Temporary leave of absence days must be specifically provided for in the recipient's plan of care. Periods of time during which a recipient is away from the facility because s/he is visiting a friend or relative are considered temporary leaves of absence; and

13. Days when recipients are away from the facility overnight on facility sponsored group trips under the continuing supervision and care of facility personnel.

(6) Rate Determination. All Non-State Operated ICF/MR providers of long-term care services under the Missouri Medicaid program who desire to have their rates changed or established must apply to the Division of Medical Services. The department may request the participation of the Department of Mental Health in the analysis for rate determination. The procedure and conditions for rate reconsideration are as follows:

(A) Advisory Committee. The director, Department of Social Services, shall appoint an advisory committee to review and make recommendations pursuant to provider requests for rate determination. The director may accept, reject or modify the advisory committee's recommendations.

1. Membership. The advisory committee shall be composed of four (4) members representative of the nursing home industry in Missouri, three (3) members from the Department of Social Services, and two (2) members which may include, but are not limited to, a consumer representative, an accountant or economist or a representative of the legal profession. Members shall be appointed for terms of twelve (12) months. The director shall select a chairman from the membership who shall serve at the director's discretion.

2. Procedures

A. The committee may hold meetings when five (5) or more members are present and may make recommendations to the department in instances where a simple majority of those present and voting concur.

B. The committee shall meet no less than one (1) time each quarter and members shall be reimbursed for expenses.

C. The Division of Medical Services will summarize each case and if requested by the advisory committee, make recommendations. The advisory committee may request additional documentation as well as require the facility to submit to a comprehensive operational review to determine if there exists an efficient and economical delivery of patient services. The review will be made at the discretion of the committee and may be performed by it or its designee. The findings from review may be used to determine the per-diem rate for the facility. Failure to submit requested documentation shall be grounds for denial of the request.

D. The committee, at its discretion, may issue its recommendation based on written documentation or may request further justification from the provider sending the request.

E. The advisory committee shall have ninety (90) days from the receipt of each complete request, provided the request is on behalf of a facility which has executed a valid Title XIX participation agreement, or the receipt of any additional documentation to submit its recommendations in writing to the director. If the committee is unable to make a recommendation within the specified time limit, the director or his/her designee, if the committee establishes good cause, may grant a reasonable extension.

F. Final determination on rate adjustment. The director's, or his/her designee's, final decision on each request shall be issued in writing to the provider within fifteen (15) working days from receipt of the committee's recommendation.

G. The director's, or his/her designee's, final determination on the advisory committee's recommendation shall become effective on the first day of the month in which the request was made, providing that it was made prior to the tenth of the month. If the request is not filed by the tenth of the month, adjustments shall be effective the first day of the following month.

(B) In the case of new construction where a valid Title XIX participation agreement has been executed, a request for a rate must be submitted in writing to the Missouri Division of Medical Services and must specifically and clearly identify the issue and the total amount involved. The total dollar amount must be supported by complete, accurate and documented records satisfactory to the single state agency. Until such time as an initial per-diem rate is established, the Division of Medical Services shall grant a tentative per-diem rate for that period. In no case may a facility receive a per-diem reimbursement rate greater than the class ceiling in effect on March 1, 1990, adjusted by the negotiated trend factor.

1. In the case of newly built facility or part thereof which is less than two (2) years of age and enters the Title XIX program on or after

November 1, 1986, a reimbursement rate shall be assigned based on the projected estimated operating costs. Advice of the advisory committee will be obtained for all initial rate determination requests for new construction. Owners of new construction which have an approved Certificate of Need, are certified for participation and which have a valid Title XIX participation agreement shall submit a budget in accordance with the principles of section (7) and other documentation as the committee may request.

2. The establishment of the permanent rate for all new construction facility providers shall be based on the second full facility fiscal year cost report prepared in accordance with the principles of section (7). This cost report shall be submitted within ninety (90) days of the close of their second full facility fiscal year. This cost report shall be based on actual operating costs. No request for an extension of this ninety (90)-day filing requirement will be considered. Any new construction facility provider which fails to timely submit the cost report may be subject to sanction under this rule and 13 CSR 70-3.030.

3. Prior to establishment of a permanent rate for new construction facility providers, the cost reports may be subject to an on-site audit by the Department of Social Services to determine the facility's actual allowable costs. Allowability of costs will be determined as described in subsection (3)(J) of this rule.

4. The cost report, audited or unaudited, will be reviewed by the Division of Medical Services and each facility's actual allowable per-diem cost will be determined. The cost report shall not be submitted to the advisory committee for review. If a facility's actual allowable per-diem cost is less than its initial per-diem reimbursement rate, the facility's rate will be reduced to its actual allowable per-diem cost. This reduction will be effective on the first day of the second full facility fiscal year.

5. If a facility's actual allowable per-diem cost is higher than its initial per-diem reimbursement rate, the facility's rate will not be adjusted; a facility shall not receive a rate increase based on review or audit of the cost report and actual operating costs.

(C) In the case of existing facilities not previously certified to participate in the Title XIX program, a request for a per-diem reimbursement rate must be submitted in writing to the Division of Medical Services and must specifically and clearly identify the issue and the total amount involved. The total dollar amount must be supported by complete, accurate and documented records satisfactory to the single state agency. Until the time as a per-diem rate is established, the Division of Medical Services shall grant a tentative per-diem rate for that period. In no case may a facility receive a per-diem reimbursement rate greater than the class ceiling in effect on March 1, 1990, adjusted by the negotiated trend factor.

1. In the case of a facility described in (6)(C) and entering the Title XIX program on or after March 1, 1990, a reimbursement rate shall be assigned based on the projected estimated operating costs. Advice of the advisory committee will be obtained for all initial rate determination requests for first full facility's fiscal year.

2. The establishment of the permanent rate for all existing facility providers shall be based on the second full facility fiscal year cost report prepared in accordance with the principles of section (7). This cost report shall be submitted within ninety (90) days of the close of their second full facility fiscal year. This cost report shall be based on actual operating costs. No request for an extension of this ninety (90)-day filing requirement will be considered. Any new construction facility provider which fails to timely submit the cost report may be subject to sanction under this rule and 13 CSR 70-3.030.

3. Prior to establishment of a permanent rate for existing facility providers, the cost reports may be subject to an on-site audit by the Department of Social Services to determine the facility's actual allowable costs. Allowability of costs will be determined as described in subsection (3)(J) of this rule.

4. The cost report, audited or unaudited, will be reviewed by the Division of Medical Services and each facility's actual allowable per-diem cost will be determined. The cost report shall not be submitted to the advisory committee for review. If a facility's actual allowable per-diem cost is less than its initial per-diem reimbursement rate, the facility's rate will be reduced to its actual allowable per-diem cost. This reduction will be effective on the second day of the first full facility fiscal year.

5. If a facility's actual allowable per-diem cost is higher than its initial per-diem reimbursement rate, the facility's rate will not be adjusted; a facility shall not receive a rate increase based on review or audit of the cost report and actual operating costs.

(D) Rate Reconsideration

1. The committee may review the following conditions for rate reconsideration:

A. Those costs directly related to a change in a facility's case mix; and

B. Requests for rate reconsideration which the director, in his/her discretion, may refer to the committee due to extraordinary circumstances contained in the request and as defined in subparagraph (4)(A)2.D.

2. The request for an adjustment must be submitted in writing to the Missouri Division of Medical Services and must specifically and clearly identify the issue and the total dollar amount involved. The total dollar amount must be supported by complete, accurate and documented records satisfactory to the single state agency. The facility must demonstrate that the adjustment is necessary, proper and consistent with efficient and economical delivery of covered patient care services.

3. However, for state fiscal years after fiscal year 1987, in no case may a facility receive a per-diem reimbursement rate higher than the class ceiling for that facility in effect on June 30th of the preceding fiscal year adjusted by the negotiated trend factor.

4. The following will not be subject to review:

A. The negotiated trend factor;

B. The use of prospective reimbursement rates; and

C. The cost base for the June 30th per-diem rate except as specified in this rule.

(E) Rate Adjustments. The department may alter a facility's per-diem rate based on --

1. Court decisions;

2. Administrative Hearing Commission decisions; or

3. Determination through desk audits, field audits and other means, which establishes misrepresentations in and/or the inclusion of unallowable costs in the cost report used to establish the per-diem rate. In these cases the adjustment shall be applied retroactively; and

(F) Rate determination shall be based on a determination of reasonable and adequate reimbursement levels for allowable cost items described in this rule which are related to ordinary and necessary care for the level of care provided for an efficiently and economically operated facility. All providers shall submit documentation of expenses for allowable cost areas. The department shall have authority to require such uniform accounting and reporting procedures and forms as it deems necessary. A reasonable and adequate reimbursement in each allowable cost area will be determined by the advisory committee with the consent of the director.

(7) Allowable Cost Areas

(A) Compensation of Owners

1. Allowance of compensation of services of owners shall be an allowable cost area, provided the services are actually performed and are necessary services.

2. Compensation shall mean the total benefit, within the limitations set forth in this plan, by the owner of the services s/he renders to the facility including direct payments for managerial, administrative, professional and other services, amounts paid by the provider for the personal benefit of the owner, the cost of assets and services which the owner receives from the provider and additional amounts determined to be the reasonable value of the services rendered by sole proprietors or partners and not paid by any method previously described.

3. Reasonableness of compensation may be determined by reference to or in comparison with compensation paid for comparable institutions or it may be determined by the other appropriate means such as the Medicare and Medicaid Provider Reimbursement Manual (HIM-15) or by other means.

4. Necessary services refers to those services that are pertinent to the operation and sound conduct of the facility, had the provider not rendered these services, then employment of another person(s) to perform the service would be necessary.

(B) Covered services and supplies as defined in section (5) of this plan.

(C) Depreciation

1. An appropriate allowance for depreciation on buildings, furnishings and equipment which are part of the operation and sound conduct of the provider's business is an allowable cost item. Finder's fees are not an allowable cost item.

2. The depreciation must be identifiable and recorded in the provider's accounting records, based on the basis of the asset and prorated over the estimated useful life of the asset using the straight line method of depreciation from the date initially put into service.

3. The basis of assets at the time placed in service shall be the lower of:

(a) the book value of the provider;

(b) fair market value at the time of acquisition;

(c) the recognized IRS tax basis;

(d) in the case of change in ownership, the cost basis of acquired assets of the owner of record on or after July 18, 1984, as of the effective date of the change of ownership; or in the case of a facility which entered the program after July 18, 1984, the owner at the time of the initial entry into the Medicaid program.

4. The basis of donated assets will be allowed to the extent of recognition of income resulting from the donation of the asset. Should a dispute arise between a provider and the Department of Social Services as to the fair market value at the time of acquisition of a depreciable asset and an appraisal by a third party is required, the appraisal cost will be shared proportionately by the Medicaid program and the facility in ratio to Medicaid recipient reimbursable patient days to total patient days.

5. Allowable methods of depreciation shall be limited to the straight line method. The depreciation method used for an asset under the Medicaid program need not correspond to the method used by a provider for non-Medicaid purposes; however, useful life shall be in accordance with the American Hospital Association's guidelines. Component part depreciation is optional and allowable under this plan.

6. Historical cost is the cost incurred by the provider in acquiring the asset and preparing it for use except as provided in this rule. Usually, historical cost includes costs that would be capitalized under generally accepted accounting principles. For example, in addition to the pur-